Los Alamos National Laboratory - Occupational Medicine Group (HSR-2)

Wellness Center

Mail Stop P955 • Phone: 667-7166 • FAX: 665-6140

WELLNESS CENTER HEALTH HISTORY QUESTIONNAIRE (Please Print)

Name (Last, First MI)		WIN (Z#):	Birth Date (00/00/00)	Gender: Male Female
MS	Group	Work Phone	E-mail Address:	

CHECK APPROPRIATE CATEGORY:

UC: TSM SSM TEC OS/GS UGS Post-Doc GRA

OTHER: Visitor Affiliate Guest Scientist Other:_____

DOE **PTLA** **KSL** **LACFD** Will you be here less than 4 months? YES NO

Regular physical activity is safe for most people. The American College of Sports Medicine (ACSM) Standards indicate that some individuals should check with their doctor concerning their participation in an exercise program. **To help us determine if you should consult with your doctor, read the following questions carefully and answer each one honestly.** If you answer **"YES"** to any *one* of questions 1-12, or answer **"YES"** to *2 or more* of questions 13-19, we will require your private physician' s concurrence in order for you to participate in exercise programs at the Wellness Center. All information will be kept confidential.

Please check Yes or No.

YES	NO		
___	___	1.	Do you have a heart condition?
___	___	2.	Have you ever experienced a stroke?
___	___	3.	Do you have epilepsy?
___	___	4.	Are you pregnant?
___	___	5.	Do you have diabetes?
___	___	6.	Do you have emphysema?
___	___	7.	Have you had an asthma attack within the last two years or are you taking asthma medication?
___	___	8.	Do you feel pain in your chest when you engage in physical activity?
___	___	9.	Do you have chronic bronchitis?
___	___	10.	In the past month, have you had chest pain when you were not doing physical activity?
___	___	11.	Do you ever lose consciousness or do you ever lose control of your balance due to chronic dizziness?
___	___	12.	Are you currently being treated for a musculo-skeletal problem that restricts you from engaging in physical activity?
___	___	13.	Has a physician ever told you or are you aware that you have high blood pressure or are you taking high blood pressure medication?
___	___	14.	Has anyone in your immediate family (parents/brothers/sisters) had a heart attack, stroke, or cardiovascular disease before age 55?
___	___	15.	Has a physician ever told you or are you aware that you have a high cholesterol level or are you taking cholesterol medication?
___	___	16.	Do you currently smoke?
___	___	17.	Are you a male over 44 years of age?
___	___	18.	Are you a female over 54 years of age?
___	___	19.	Are you currently exercising LESS than 1 hour per week? If you answered no, please list your activities. _____ _____
___	___	20.	Are you currently taking medication for blood pressure or a heart condition? _____ _____

I have read, understood, and completed this questionnaire. Any questions that I had were answered to my full satisfaction. I understand I will complete an updated Health History Questionnaire if I have a known change in my health status.

Signature: _____ Date:_____

Social Security #: _____/_____/_____ Foreign National # (if applicable): _____

For Wellness Center Staff Use ONLY

Cleared to Exercise *(circle)*: **Yes No** Staff Signature: _____ Date:_____
If NO, list #s above as reasons. _____

Physicians Approval Received: Date:_____ **Cleared to Exercise:** Date: _____ Staff Signature:_____

Tour: _____ *Update*:_____ *JCNNM Verified:* _____ *Badgereader*:_____

Video: _____ *Verified*: _____ *JCNNM Copied*: _____ *Database*:_____